PRINTED: 12/10/2014 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157163	B. WING _				C 01/2014
	ROVIDER OR SUPPLIER		•	13	REET ADDRESS, CITY, STATE, ZIP CODE 51 SILHAVY RD STE 200 ALPARAISO, IN 46383		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
G 000	INITIAL COMMENTS	3	G	000			
	This was a federal h investigation.	ome health complaint					
	Federal deficiencies	66773 - Substantiated: related to the allegation are ficiencies are also cited.					
	Survey Date: 9/24/1	4 - 10/1/14					
	Facility #: IN005336						
	Medicaid #: 1002644	20A					
	Health Nurse Survey	Weiss, MSN, RN, Public					
	providing its own hor competency evaluati years beginning 8/14 found out of complian Participation 42 CFR						
		formed of the above-stated conference held on 9/25/14					
	_	ended due to additional w and interview on 10/1/14.					
	Quality Review: Joyc	e Elder, MSN, BSN, RN					
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUI	RE		TITLE		(X6) DATE

10/15/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: IN005336

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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G 000	Continued From page	e 1 r 9, 2014	G	000					
G 121	11/19/14. je 484.12(c) COMPLIAN PROFESSIONAL ST The HHA and its staff professional standard		G	121			10/15/14		
	Based on interview, and review of policies agency failed to ensu (Employee A) perforn care in accordance w	re the registered nurse ned tracheostomy / ventilator							
	included a plan of car of 8/4/14 - 10/2/14. Employee A had diffic (tracheostomy) tube of 9/5/14 at 11:20 AM. Temployee A on a clini 11:20 AM and on a truthis time frame, the pocumentation at the evidence that a small for patient safety if differenserting the outer tresuscitator bag had	start of care 6/10/13, re for the certification period cocumentation evidenced bulty with an outer trach change that occurred on this was documented by ical note dated 9/5/14 at eatment flow sheet. During attent had a pulse of 98. It is visit on 9/5/14 failed to er trach tube was available efficulty occurred in trach tube and a manual been used. The patient did scitate orders. Agency policy							

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	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SILHAVY RD STE 200 VALPARAISO, IN 46383		10/01/2014	
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G 121	A. The plan of coorders for a outer trace occurred on 9/5/14. Order had not been puntil 9/25/14 and was at that time. 1.) A clinical Orders" with a date of to plan of care 8/4/14 Nurse] Trach Care; of cannula." 2.) On 9/24 indicated performing on 9/5/14 at approximal A indicated that after tube he encountered outer trach tube due patient #1. He called for the procedure. The was 95 / 63 and oxyold dropping so he had attached on the circuit and patrach tube to get air emergency respondent encounter with an amouth and nose and the hospital. He indicated that indicated that after tube to get air emergency respondent with an amouth and nose and the hospital. He indicated that indicated that all the indicated that after the patient with an amouth and nose and the hospital. He indicated that all the indicated that after the patient with an amouth and nose and the hospital. He indicated that after the patient with an amouth and nose and the hospital.	e not followed as evidenced are failed to include physician	G	, , , , , , , , , , , , , , , , , , ,			
	raised, and then low procedure. He indic changes had not occ	nd of the bed had been ered for this outer trach tube ated the outer trach tube curred in July or August. The s used to give and note care					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
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G 121	nursing staff. He wo record from the mont treatment record for the plan of care from treatment changes o why the outer trach to current plan of care. Outer trach tube charindicated once havin tube change. He did difficulty occurred (Ticlinical record). He vent and trach care of and told the clinical of administrator indicates sign orders presente marketer who had visuaround 5:30 PM. 4.) On 10/1 nurse and office mar modification order wat his office on 9/25/The physician's staff refused to sign the office of the physician prior to the physician	aily basis by the skilled ald copy the treatment the before to make a new the current month. He used the clinical record if any occurred. He did not know tabe change was not on the He had completed many neges with this patient and go difficulty with this trach not remember when the insi was not found in the indicated taking himself off of patients after this incident director of his request. In the physician refused to do to the physician refused to do to the physician by the sited his office on 9/25/14. In the physician had refer since this was not a task negligible assigned to the home order had not been given to this date. In failed to evidence there to the physical male of the physician that the bedside of patient mployee A had difficulty	G	121				
	reinserting the new of Documentation failed manually resuscitate	I to evidence Employee A						

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G 121	of patient #1 titled "Cl failed to evidence any tubes were in the hor manually resuscitate" 2.) On 9/24/indicated not having at bedside of patient at bedside of patient at the did indicate having the normal size. He hairway at the T on the reinserted the outer to patient at this incident. 2. The following ager were not followed as A. The agency procedures from pathome Health Care Romanual with no date at tube during suctioning lead to tube displacer tube accidentally falls tube immediately. In with a patent airway, should be taken: 1. It tube, using the sterile Reinsert the original thand use the manual resummended during the patient's color and count his pulse rate. pulse rate changes si insert the tube, occluding the patient's color and count his pulse rate.	nent from the clinical record inical Note" dated 9/5/14 v smaller size outer trach ne. Employee A did not the patient. 214 at 5:20 PM, Employee A a smaller trach tube on hand #1 on 9/5/14 at 11:20 AM. In grammy outer trach tubes of nead attached a nebulizer or circuit and partially reach tube to get air to the st. 129 and procedures evidenced below: 130 and procedures evidenced below: 140 and procedures evidenced below: 151 and procedures evidenced below: 152 and procedures evidenced below: 153 and procedures evidenced below: 154 and procedures evidenced below: 155 and procedures evidenced below: 156 and attached a nebulizer evidenced below: 157 and procedures evidenced below: 158 and procedures evidenced below: 159 and procedures evidenced below: 150 and procedur	G	121				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	· /	COMPLETED		
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G 121	patient can not breath reinsert the tube with until reinsertion is pondave access to a trace smaller than the tube this tube will be easied the airway is swollen. B. The agency pof Home Ventilators" provide guidelines for other caregivers who dependent clients, to management of high setting, to promote set to Registered Nurses activities including concentrations. C. The agency pracheostomy Tube" change the client's trace to Registered Nurses hands 2. DON clear client per Tracheostomy Tube client per Tracheostomy Tubes hands 2. DON clear client per Tracheostomy ties; had ominant hand. 6. Fendominant hand. 6. Fendominant hand. 7. Gently remulate and insert lubric obturator into stomal inward. 8. Following insert inner cannula acclient is on a ventilate seconds. 9. Secure ties and dressing per	an be obtained. If the he on his own, you must in 30 seconds or ventilate ssible. You may want to the tube whose size is 1 size the patient uses. Inserting er than the standard tube if "rocedure titled "Management with no date stated, "To rhome health nurses and care for ventilator promote safety in tech care in the home elf care in the home. Applies and the care in the home. Applies and the care coordination ontact with physician." "rocedure titled "Changing a with no date stated, "To acheostomy tube applies and gloves. 3. Suction the my suctioning procedure. 4. stomy tube 5. Cut existing old tube in place with non-pick up new tube in dominant love existing tracheostomy atted outer cannula with Insert downward and insertion, remove obturator, and 'lock' it into place. If the or, reconnect within 30 the tube in place with clean tracheostomy Care eck cuff seal for leakage."	G 1	21				

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G 121	includes a compreh securing the tube, in patency by suctionin communication to E. The agency Care FYI's" with not the obturator availal trach 1 size smaller case you are unabled. F. The procedure Ventilation" with not hypoxia due to alter respirations. To prosupport applies Fiventilation 1. Admin resuscitation or amburing suctioning, tree ventilator failure. 2. Ambu Bag, disconn connect the bag valuation of the bag valuation of the policy time and regulation of the regulatory boothe home care industrial to failure. The agency of Care" with a date policy of Anchor Hohealth care services general supervision based on a written festablished and per services general supervision based on a written festablished and per services general supervision based on a written festablished and per services general supervision based on a written festablished and per services general supervision based on a written festablished and per services general supervision based on a written festablished and per services general supervision based on a written festablished and per services general supervision based on a written festablished and per services general supervision based on a written festablished and per services general supervision based on a written festablished and per services general supervision based on a written festablished and per services general supervision based on a written festablished and per services general supervision based on a written festablished and per services general supervision based on a written festablished and per services general supervision based on a written festablished and per services general supervision based on a written festablished and per services general supervision based on a written festablished and per services general supervision based on a written festablished and per services general supervision based on a written festablished and per services general supervision based on a written festablished and per services general supervision based on a written festablished and per serv	e" with no date stated, "This ensive plan that includes inflating the cuff, maintaining ing and ensuring maintain airway patency." procedure "Tracheostomy date stated, "Always keep ble for emergencies keep a available at the bedside in eto insert the regular size." In etitled "Mechanical date stated, "To prevent ation or cessation of evide uninterrupted ventilator elegistered Nurses Manual ister air to the lungs through ou bag when needed, such as acheostomy care during When using resuscitation or eet the ventilator circuit and eto the tracheotomy tube." It et "Agency Compliance" with ted, "It is the policy to compliance with the laws, is of all federal, state, and dies having jurisdiction over stry." policy titled "Physician's Plan of 9/17/12 stated, "It is the me Health Care that home is are furnished under the of a doctor of medicine	G 1	21				

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G 121	patient's condition. implemented only in care established by I. The agency p Physician's Orders" "It is the policy to provide patient / clie To revise, amend, or Plan of care." J. The agency p Services" with a date Home Health Service high tech home heal client / clients Se Nursing care serv are provided in accoplan of care Deve care plan, if directed regulations. Direct r counseling and teac and the patient / clie the implementations health care regimen regime under the dir physician. Initiate al	are services relative to the All clinical services are accordance with a plan of a physician's written orders." olicy titled "Verification of with a date of 9/17/12 stated, obtain physician orders to nt treatment and services. 2. supplement the Physician's supple	G 1	21			
	provide high tech nu under the direction of physician." K. The agency provides with a date care services are prophysician's plan of control of	eded 6. Anchor will rsing, e.g. ventilators of the patient / client's colicy titled "Nursing Care e of 9/1/06 stated, "Nursing covided in accordance with the are The Clinical supervisor olete the nursing initial and					

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		457462	D WING				С
		157163	B. WING			10	/01/2014
	ROVIDER OR SUPPLIER HOME HEALTH CARE			1	TREET ADDRESS, CITY, STATE, ZIP CODE 351 SILHAVY RD STE 200 'ALPARAISO, IN 46383		
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G 121	the OASIS data sets appropriate time poin revise the nursing car federal / state / local care collaborate in coordination of the to execute the medical a licensed physician nursing staff sent to compare the collaborate in the collaborate	ive assessments including at appropriate time points at ts as required, develop or re plan, as directed by regulations, direct nursing the implementation and tal health care regimen and regime under the direction of Anchor will assure that eare for high tech patients/s in the specific care modality at / client."		121			10/15/14
C 141	Based on clinical recorded procedure review, do file review, and intervipersonnel policies we personnel records revagency failed to ensure communicated with the tracheostomy / ventile reviewed of patients vand G 144). The cumulative effect resulted in the agency requirements of the C 484.14 Organization, Administration.	ne physician about ator care in 1 of 7 records with a tracheostomy (G 143 of these systemic problems y's inability to meet the condition of Participation Services, and		141			10/15/14
G 141	484.14(e) PERSONN	IEL POLICIES	G	141			10/15/14

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G 141	policies.	and patient care are riate, written personnel clude qualifications and	G	141			
	Based on personnel review and interview, the personnel policies employee records rev	not met as evidenced by: file, document, and policy the agency failed to ensure s were followed in 7 of 8 viewed (Employees A - G red for tracheostomy / 1 - 7).					
	Findings						
	hire 5/5/11, failed to e assessment or a combeen completed on vote before the staff members, patients with venue. 2. Employee B, Licer date of hire 5/26/07, for review assessment of test had been complet tracheostomy care be	efore this staff member					
	to evidence a peer re	, date of hire 1/12/11, failed view assessment or a n test had been completed					
	on ventilator / trached	ostomy care before this staff tient #2, an active patient					

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G 141	evidence a peer revicomprehensive writt on ventilator / trache member care for pat tracheostomy and ventilator / tracheostomy and tracheostomy caread for patient #6 7. Employee G, LPN to evidence a peer recomprehensive writt on tracheostomy caread for patient #6 8. On 9/25/14 at 4:4 human resources diffles were not compland tests and compensionel files. Employee G, the file did not show competency was compersonnel files reviewed.	date of hire 7/26/14, failed to lew assessment or a len test had been completed eostomy care before this staff tient #7, an active patient with lentilator care. In the staff tient with lentilator care before this staff lent with lentilator care. In the staff lent with lentilator care before this staff lent with lentilator care before this staff lentilator with lentilator care.	G 14		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		_	(X3) DATE SURVEY COMPLETED	
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G 141	Continued From page	± 11	G	41			
	with a date of 9/10/12 and the appropriate c	titled "Orientation Process" stated, "Human resources linical supervisor will ensure care providers are oriented tems."					
G 143	Staff - Ventilator" with "Mechanical ventilation will be cared for by queservices are provided Procedure: 1. RNs / duty ventilator patient competency in ventilator patient accomplished in two wemployees with little or those who feel they extended orientation Anchor's ventilator catest and peer review independently caring patient / client. 1.2 For ventilator experience, test must be complete complete the orientatikept in the personnel	LPNs who care for private / clients must demonstrate tor care. This may be ways: 1.1 For those or no ventilator experience y would benefit from an program: attendance at re training including a post n a home, prior to for the ventilator dependent or those employees with a written comprehensive ed. 2. RN / LPNs will fon skills checklist which is file on hire and annually."	G	43			10/15/14
	to ensure that their ef	ng services maintain liaison forts are coordinated rt the objectives outlined in					
		not met as evidenced by: ord review, agency policy					

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G 143	failed to ensure all pethe physician about trin 1 of 7 records reviet tracheostomy (#1). Findings 1. Clinical record #1, diagnosis of chronic revidence communica agency staff and the performing outer track changes with patient 2. On 9/25/14 at 5:20 Registered Nurse, individe with the outer trach to the past. 3. On 10/1/14 at 11 A office manager indicate been notified that the outer trach tube change on 9/5/1 physician was the physician was the physician was the physician was the physician to provide coopatients The clinical supervisor, or designating the case manager to implement the physician that the physician was the physician was the physician that the case manager to implement the physician that the physician was the physician was the physician was the physician was the physician that the physician was the physician that the physician was the physicia	expandinterview, the agency ersonnel communicated with racheostomy / ventilator care exwed of patients with a start of care 6/10/13 with a respiratory failure, failed to tion notes between the physician about difficulty heostomy (trach) tube #1. DPM, Employee A, dicated having difficulties abe change with patient #1 in AM, a physician's nurse and ted the physician had not agency was performing ges including the outer trach 4 by Employee A. The sysician for patient #1. It titled "Coordination of Care" estated, "It is the policy of ordination of care for all al coordinator, clinical ated primary RN acts as coordinate services to ian's plan of care through in."	G	143			

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ANCHOR	HOME HEALTH CARE			1351 SILHAVY RD STE 200 VALPARAISO, IN 46383			
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G 143		care for ventilator promote safety in tech care in the home elf care in the home. Applies Care coordination	G	143			
G 144			G	144			10/15/14
	Based on clinical rec and procedure review failed to ensure all pe the physician about tr	not met as evidenced by: ord review, agency policy n, and interview, the agency ersonnel communicated with eacheostomy / ventilator care ewed of patients with a					
	diagnosis of chronic revidence communicate agency staff and the performing outer track changes with patient 2. On 9/25/14 at 5:20 Registered Nurse, incompared to the revidence of the performing outer tracks.						

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ANCHOR	HOME HEALTH CARE				351 SILHAVY RD STE 200 /ALPARAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 144	office manager indica been notified that the outer trach tube chan tube change on 9/5/14 physician was the physician to a decide the case manager to a supervisor, or designate the case manager to a supervisor, or designate case manager to the treatment plan. 5. The agency proceed Home Ventilators " with provide guidelines for other caregivers who dependent clients, to management of high setting, to promote set to Registered Nurses activities including control of the control o	AM, a physician's nurse and ted the physician had not agency was performing ges including the outer trach 4 by Employee A. The visician for patient #1. Ititled "Coordination of Care" stated, "It is the policy of ordination of care for all al coordinator, clinical ated primary RN acts as coordinate services to ian's plan of care through n." Iture titled "Management of the no date stated, "To home health nurses and care for ventilator promote safety in tech care in the home. Applies Care coordination		144			10/15/14
	Based on document agency policy and pro interview, it was deter ensure treatments we on the plan of care for	not met as evidenced by: review, clinical record and ocedure review, and rmined the agency failed to ere provided only as ordered r 1 of 7 records reviewed of ostomy (See G 158 and G					

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 12/10/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		157163	B. WING _			C 10/01/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1351 SILHAVY RD STE 200 VALPARAISO, IN 46383	•	10/01/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
G 156	treatments completed clinical records review tracheostomy tube characteristic performed (See G 15). The cumulative effect resulted in the agency compliance with the Classification of the complete supervision. 484.18 ACCEPTANC MED SUPER Care follows a writter	sure the plan of care change a tracheostomy tube d by the staff (A) for 1 of 4 wed of patients with outer nanges the agency 9). It of these systemic problems by being found out of Condition of Participation of Patients, Plan of Care, and SE OF PATIENTS, POC,	G 1			10/15/14
	Based on clinical recand interview, the again treatments were the plan of care for 1 patients with a tracher Findings 1. Clinical record #1, included a plan of care of 8/4/14 - 10/2/14. Employee A had diffic (tracheostomy) tube 9/5/14 at 11:20 AM. To	start of care 6/10/13, re for the certification period Documentation evidenced culty with an outer trach change that occurred on This was documented by ical note dated 9/5/14 at				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	, ,	OATE SURVEY COMPLETED
		157163	B. WING _			C 10/01/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SILHAVY RD STE 200 VALPARAISO, IN 46383		10/01/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 158	Continued From pag	e 16	G 1	58		
	orders for a outer tra occurred on 9/5/14. order had not been p until 9/25/14 and was at that time.	This unsigned modified resented to the physician s not signed by the physician				
	Orders" with a date of to plan of care 8/4/14	al document titled "Modified of 8/4/14 stated, "Addendum I - 10/2/14: SN [Skilled change monthly, inner				
	indicated performing on 9/5/14 at approxing A indicated that after tube he encountered outer trach tube due patient #1. He called for the procedure. The was 95 / 63 and oxygoropping so he had the up. He had attached on the circuit and paterach tube to get air the emergency respondent the patient with an air mouth and nose and the hospital. He indicated in the encountered in the indicated in the	an outer trach tube change mately 11:20 AM. Employee he pulled out the outer trach difficulty reinserting the new to a coughing spell by 1911. He lowered the bed he patient's blood pressure gen saturation rate was he oxygen turned all the way a nebulizer airway at the T tially reinserted the outer o the patient. When the ers arrived, they ventilated inbu bag at the patient's transported the patient to eated the patient's G tube imped off 20 minutes prior to d of the bed had been				
	procedure. He indica changes had not occ treatment record was to the patient on a da	ered for this outer trach tube ated the outer trach tube urred in July or August. The sused to give and note care ally basis by the skilled uld copy the treatment				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		157163	B. WING			C 10/01/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SILHAVY RD STE 200 VALPARAISO, IN 46383	ı	10/01/2014
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 158	treatment record for the plan of care from treatment changes of why the outer trach to current plan of care. Outer trach tube chaindicated once having tube change. He did difficulty occurred (Toclinical record). 3.) On 9/28 administrator indicated sign orders presented marketer who had viaround 5:30 PM. 4.) On 10/10 nurse and office man of patient #1) indicated order was presented on 9/25/14 by the agphysician's staff indirefused to sign the conductor of the plant of the conductor of the plant of the plan	th before to make a new the current month. He used in the clinical record if any occurred. He did not know tube change was not on the He had completed many inges with this patient and ing difficulty with this trach not remember when the this was not found in the state of the physician refused to the physician by the sited his office on 9/25/14 1/14 at 11 AM, physician's mager (this was the physician led the above modification of the physician at his office gency marketer. The cated the physician had order since this was not a task range) assigned to the home order had not been given to	G 1	58		
	Care" with a date of policy of Anchor Hor health care services general supervision based on a written F established and peri doctor to ensure the	v titled "Physician's Plan of 9/17/12 stated, "It is the me Health Care that home are furnished under the of a doctor of medicine Plan of Care that is odically reviewed by the appropriateness and are services relative to the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		157163	B. WING _			C 10/01/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SILHAVY RD STE 200 VALPARAISO, IN 46383	.	16/6 1/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 158	implemented only in	All clinical services are accordance with a plan of	G ²	58		
	3. The agency policy Physician's Orders" wilt is the policy to oprovide patient / clien To revise, amend, or Plan of care."	with a date of 9/17/12 stated, obtain physician orders to at treatment and services. 2. supplement the Physician's a titled "Nursing Care				
G 159	care services are prophysician's plan of care or staff RN will complete ongoing comprehens the OASIS data sets appropriate time point revise the nursing cafederal / state / local care collaborate in coordination of the to execute the medical a licensed physician nursing staff sent to complete the medical of the care in the care can be set to care the medical of the care care the care care the care care care care care care care car		G ?	59		10/15/14
	The plan of care deve the agency staff cover including mental state equipment required, prognosis, rehabilitat limitations, activities p	eloped in consultation with sers all pertinent diagnoses, us, types of services and frequency of visits, ion potential, functional permitted, nutritional ations and treatments, any				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		157163	B. WING _			C 10/01/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SILHAVY RD STE 200 VALPARAISO, IN 46383		10/01/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
G 159	Continued From pag instructions for timely any other appropriate	discharge or referral, and	G 1	59		
	Based on clinical re- review and interview the plan of care inclu- tracheostomy tube tr staff (A) for 1 of 4 c	not met as evidenced by: cord and agency policy , the agency failed to ensure ided an order to change a eatments completed by the linical records reviewed (#1) tracheostomy tube changes d.				
	Findings					
	included a plan of ca of 8/4/14 - 10/2/14. Employee A had diffi (tracheostomy) tube 9/5/14 at 11:20 AM.	, start of care 6/10/13, re for the certification period Documentation evidenced culty with an outer trach change that occurred on This was documented by nical note dated 9/5/14 at reatment flow sheet.				
	orders for a outer tra occurred on 9/5/14. order had not been p	are failed to include physician ch tube change that This unsigned modified presented to the physician is not signed by the physician				
	Orders" with a date of to plan of care 8/4/14	al document titled "Modified of 8/4/14 stated, "Addendum 4 - 10/2/14: SN [Skilled change monthly, inner				
		l/14 at 5:20 PM, Employee A an outer trach tube change				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
			71. 501251			(C
		157163	B. WING			10/	01/2014
	ROVIDER OR SUPPLIER HOME HEALTH CARE		•	13	TREET ADDRESS, CITY, STATE, ZIP CODE 851 SILHAVY RD STE 200 ALPARAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 159	A indicated that after tube he encountered outer trach tube due patient #1. He called for the procedure. The was 95 / 63 and oxyg dropping so he had the up. He had attached on the circuit and partrach tube to get air the emergency respondent the patient with an armouth and nose and the hospital. He indicated incident, the hear raised, and then lower procedure. He indicated the patient on a dark to the plan of care from the plan of care from the plan of care from the plan of care. Outer trach tube charmindicated once having tube change. He did difficulty occurred (The clinical record).	nately 11:20 AM. Employee he pulled out the outer trach difficulty reinserting the new to a coughing spell by 1911. He lowered the bed he patient's blood pressure gen saturation rate was he oxygen turned all the way a nebulizer airway at the T tially reinserted the outer to the patient. When the ers arrived, they ventilated inbu bag at the patient to ated the patient's transported the patient to ated the patient's G tube in a tube at the couter trach tube ared for this outer trach tube ared for this outer trach tube ared to give and note care ally basis by the skilled all copy the treatment in before to make a new the current month. He used the clinical record if any occurred. He did not know tube change was not on the He had completed many neges with this patient and g difficulty with this trach not remember when the his was not found in the	G	159			
	administrator indicate sign orders presented	ed the physician refused to d to the physician by the sited his office on 9/25/14					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		157163	B. WING _			C
	ROVIDER OR SUPPLIER	10.130		STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SILHAVY RD STE 200 VALPARAISO, IN 46383		10/01/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
G 159	nurse and office man of patient #1) indicate order was presented on 9/25/14 by the agrouphysician's staff indice refused to sign the or (outer trach tube chan health agency. This the physician prior to 2. The agency policy Care" with a date of spolicy of Anchor Homelth care services general supervision of based on a written Plestablished and period doctor to ensure the necessity of home capatient's condition. Implemented only in care established by a The physician's Plan dated within a reason otherwise specified by regulations." 3. The agency policy Physician's Orders" will is the policy to oprovide patient / clier To revise, amend, or Plan of care."	/14 at 11 AM, physician's ager (this was the physician ed the above modification to the physician at his office ency marketer. The sated the physician had refer since this was not a task nge) assigned to the home order had not been given to this date. titled "Physician's Plan of 2/17/12 stated, "It is the ne Health Care that home are furnished under the of a doctor of medicine an of Care that is odically reviewed by the appropriateness and are services relative to the All clinical services are accordance with a plan of a physician's written orders of Care must be signed and hable amount of time, unless by state or federal titled "Verification of with a date of 9/17/12 stated, obtain physician orders to at treatment and services. 2. supplement the Physician's	G 1			10/15/14
G 165	484.18(c) CONFORM ORDERS	MANCE WITH PHYSICIAN	G 1	65		10/15/14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		157163	B. WING_		1	C 0/01/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SILHAVY RD STE 200 VALPARAISO, IN 46383		0/01/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 165	Continued From page 22 Drugs and treatments are administered by agency staff only as ordered by the physician.		G 1	65		
	Based on clinical rec and interview, the age and treatments were	not met as evidenced by: ord review, policy review, ency failed to ensure visits provided only as ordered on of 7 records reviewed of ostomy (#1).				
	Findings					
	of 8/4/14 - 10/2/14. Employee A had diffic (tracheostomy) tube 9/5/14 at 11:20 AM. T	e for the certification period documentation evidenced culty with an outer trach change that occurred on this was documented by cal note dated 9/5/14 at				
	orders for a outer trac occurred on 9/5/14. Torder had not been pro-	re failed to include physician the tube change that This unsigned modified resented to the physician not signed by the physician				
	Orders" with a date of	l document titled "Modified f 8/4/14 stated, "Addendum - 10/2/14: SN [Skilled nange monthly, inner				
	indicated performing	114 at 5:20 PM, Employee A an outer trach tube change nately 11:20 AM. Employee				

		MEDIO/ ND OLIVIOLO				OIVID IVE	7. 0000 000 1
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(С
		157163	B. WING			10/	01/2014
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ANCHOR	HOME HEALTH CARE				351 SILHAVY RD STE 200 /ALPARAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 165	A indicated that after tube he encountered outer trach tube due patient #1. He called for the procedure. The was 95 / 63 and oxygor dropping so he had the up. He had attached on the circuit and partrach tube to get air to the patient with an armouth and nose and the hospital. He indicated incident, the hear aised, and then lower procedure. He indicated had not occure treatment record was to the patient on a danursing staff. He work record from the mont treatment record for the plan of care from treatment changes of why the outer trach tube charge. He did difficulty occurred (The clinical record). 3.) On 9/25 administrator indicates sign orders presented.	the pulled out the outer trach difficulty reinserting the new to a coughing spell by 1911. He lowered the bed the patient's blood pressure ten saturation rate was the oxygen turned all the way a nebulizer airway at the Totally reinserted the outer to the patient. When the tens arrived, they ventilated inbuild bag at the patient's transported the patient to atted the patient's G tube in the patient's outer trach tube in the patient to atted the outer trach tube in the patient to atted the outer trach tube in the patient to a tend to give and note care in the patient to a tend to give and note care in the before to make a new the current month. He used the clinical record if any courred. He did not know the change was not on the the had completed many toges with this patient and the difficulty with this trach the physician refused to did to the physician refused to did to the physician by the sited his office on 9/25/14	G	165			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		157163	B. WING _			C 10/01/2014	
	ROVIDER OR SUPPLIER HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CO 1351 SILHAVY RD STE 200 VALPARAISO, IN 46383	•	10/01/2014	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
G 165	nurse and office may of patient #1) indicated reason 9/25/14 by the aphysician's staff increfused to sign the (outer trach tube of health agency. This the physician prior of the physician of the physician of the patient's condition. In the physician's of the patient's condition. In the physician's of the provide patient / clin of the physician of the	d/1/14 at 11 AM, physician's anager (this was the physician ated the above modification at the physician at his office agency marketer. The dicated the physician had order since this was not a task mange) assigned to the home s order had not been given to	G 1	65			
	Services" with a da care services are p physician's plan of or staff RN will com	te of 9/1/06 stated, "Nursing rovided in accordance with the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		ATE SURVEY DMPLETED
				<u> </u>		С
		157163	B. WING _			10/01/2014
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ANCHOR	HOME HEALTH CARE		1351 SILHAVY RD STE 200			
ANOHOR	TOME TIEAETH GARE			VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 165	appropriate time poin revise the nursing car federal / state / local r care collaborate in coordination of the to execute the medical r a licensed physician . nursing staff sent to co	at appropriate time points at ts as required, develop or re plan, as directed by regulations, direct nursing the implementation and tal health care regimen and regime under the direction of Anchor will assure that are for high tech patients/s in the specific care modality at / client."	G 1			10/15/14
	Based on clinical recoprocedure review, and determined the agency nursing services were on the plan of care for patients with a trache to ensure the register tracheostomy / ventile agency policy and procedure (See G 174); a registered nurse comphysician about trach being provided and controlled to the controlled to t	cy failed to ensure skilled e provided only as ordered r 1 of 7 records reviewed of ostomy (See G 170); failed ed nurse performed ator care in accordance with ocedures in 1 of 1 closed and failed to ensure the municated with the eostomy / ventilator care oordinated care with the cords reviewed of patients				
G 170	resulted in the agency	Condition of Participation g Services.	G 1	70		10/15/14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	COMF	(X3) DATE SURVEY COMPLETED		
		157163	B. WING _			C / 01/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SILHAVY RD STE 200 VALPARAISO, IN 46383	10	01/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
G 170	accordance with the	killed nursing services in	G 1	70			
	Based on clinical red and interview, the ag nursing services were	cord review, policy review, ency failed to ensure skilled e provided only as ordered or 1 of 7 records reviewed of					
	Findings						
	included a plan of ca of 8/4/14 - 10/2/14. I Employee A had diffic (tracheostomy) tube 9/5/14 at 11:20 AM.	, start of care 6/10/13, re for the certification period Documentation evidenced culty with an outer trach change that occurred on This was documented by iteal note dated 9/5/14 at reatment flow sheet.					
	orders for a outer tra- occurred on 9/5/14. order had not been p	are failed to include physician ch tube change that This unsigned modified resented to the physician s not signed by the physician					
	Orders" with a date of to plan of care 8/4/14	al document titled "Modified of 8/4/14 stated, "Addendum I - 10/2/14: SN [Skilled change monthly, inner					
	indicated performing on 9/5/14 at approxir	n/14 at 5:20 PM, Employee A an outer trach tube change mately 11:20 AM. Employee he pulled out the outer trach					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		157163	B. WING	_		400	-
	ROVIDER OR SUPPLIER HOME HEALTH CARE	13/103	1 2	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 351 SILHAVY RD STE 200	10/	01/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	ALPARAISO, IN 46383 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 170	outer trach tube due to patient #1. He called for the procedure. The was 95 / 63 and oxyg dropping so he had the up. He had attached on the circuit and partrach tube to get air to emergency responde the patient with an an mouth and nose and the hospital. He indicateding had been claim this incident, the head raised, and then lower procedure. He indicated and the patient on a danursing staff. He wourecord from the month treatment record for the plan of care from treatment changes of why the outer trach to current plan of care. Outer trach tube change. He did a difficulty occurred (The clinical record).	difficulty reinserting the new to a coughing spell by 911. He lowered the bed the patient's blood pressure en saturation rate was the oxygen turned all the way an ebulizer airway at the Totally reinserted the outer to the patient. When the tres arrived, they ventilated the bag at the patient's transported the patient to the patient to the patient's G tube to a cought of the patient's G tube to a cought of the patient's G tube to a cought of the patient to a cought of the patient's G tube to a cought of the patient to a cought of the patient's G tube to a cought of the patient to a cought of the patient's G tube to a cought of the patient's G tube to a cought of the patient to a cought of the patient's G tube to a cought of the patient of the p	G	170			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		157163	B. WING		C 10/01/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SILHAVY RD STE 200 VALPARAISO, IN 46383	10.0.12011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLET	
G 170	nurse and office mar of patient #1) indicate order was presented on 9/25/14 by the agphysician's staff indirefused to sign the of (outer trach tube chahealth agency. This the physician prior to 2. The agency policy Care" with a date of policy of Anchor Hornhealth care services general supervision based on a written Pestablished and peridoctor to ensure the necessity of home capatient's condition. implemented only in care established by 3. The agency policy Physician's Orders" "It is the policy to provide patient / clied To revise, amend, or Plan of care." 4. The agency policies Services with a date care services are prophysician's plan of cor staff RN will compongoing comprehensions.	1/14 at 11 AM, physician's nager (this was the physician ed the above modification I to the physician at his office gency marketer. The cated the physician had order since this was not a task ange) assigned to the home order had not been given to be this date. If titled "Physician's Plan of 9/17/12 stated, "It is the ne Health Care that home are furnished under the of a doctor of medicine	G 17	70		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
			7. BOILDI			(C
		157163	B. WING			10/	01/2014
	ROVIDER OR SUPPLIER HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SILHAVY RD STE 200 VALPARAISO, IN 46383	· •		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE		(X5) COMPLETION DATE
G 170	revise the nursing car federal / state / local r care collaborate in coordination of the to execute the medical r a licensed physician nursing staff sent to clients are competent required by the patier 484.30(a) DUTIES OF NURSE	ts as required, develop or re plan, as directed by regulations, direct nursing the implementation and tal health care regimen and regime under the direction of Anchor will assure that eare for high tech patients/ tin the specific care modality at / client."		170			10/15/14
	This STANDARD is r Based on interview, r and review of policies agency failed to ensu (Employee A) perform care in accordance w of 1 closed record (1) Findings 1. Clinical record #1, included a plan of car of 8/4/14 - 10/2/14 the had difficulty with an of tube change that occur This was documented note dated 9/5/14 at a flow sheet. During the had pulse of 98. Doc	not met as evidenced by: review of clinical records, and procedures, the re the registered nurse ned tracheostomy / ventilator ith agency procedures in 1					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		157163	B. WING			C
	ROVIDER OR SUPPLIER HOME HEALTH CARE	137103		STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SILHAVY RD STE 200 VALPARAISO, IN 46383	<u> </u>	10/01/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 174	reinserting the outer a manual resuscitated Agency policy and properties as evidenced by the The plan of care orders for a outer traceocurred on 9/5/14. Order had not been puntil 9/25/14 and was at that time. A. A clinical do Orders" with a date of the plan of care 8/4/14 Nurse] Trach Care; of cannula." B. On 9/24/indicated performing on 9/5/14 at approximal A indicated that after tube he encountered outer trach tube due patient #1. He called for the procedure. The was 95 / 63 and oxyoldropping so he had the patient with an amouth and nose and the hospital. He indicated feeding had been classifications are defined in the called for the procedure. The had attached the patient with an amouth and nose and the hospital. He indicated feeding had been classifications, the head the called feeding had been classifications, the head the patient, the head the patient with an amouth and nose and the hospital. He indicated the patient, the head the patient with an amouth and nose and the hospital, the head the patient with an amouth and nose and the hospital.	tient safety if a difficulty in trach tube occurred and that or bag had been used. The rocedures were not followed following:	G 1	74		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		157163	B. WING _			C 0/01/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1351 SILHAVY RD STE 200 VALPARAISO, IN 46383		0/01/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G 174	changes had not occi treatment record was to the patient on a da nursing staff. He wou record from the mont treatment record for the plan of care from treatment changes of why the outer trach to current plan of care. Outer trach tube chanindicated once having tube change. He did difficulty occurred (The clinical record). He is vent and trach care of and told the clinical design orders presented marketer who had visuaround 5:30 PM. D. On 10/1/1. The physician's staff refused to sign the or [outer trach tube chan health agency. This of the physician prior to 2. The following agents.	atted the outer trach tube curred in July or August. The used to give and note care illy basis by the skilled ald copy the treatment in before to make a new he current month. He used the clinical record if any courred. He did not know ube change was not on the He had completed many ges with this patient and go difficulty with this trach not remember when the not remember when the not remember when the not reduce taking himself off f patients after this incident irrector of his request. 4 at 5:40 PM, the ad the physician refused to do to the physician refused to do to the physician by the sited his office on 9/25/14 4 at 11 AM, a physician's ager indicated the above as presented to the physician had der since this was not a task nge] assigned to the home order had not been given to this date.	G 1	74			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		157163	B. WING			C 0/01/2014	
	ROVIDER OR SUPPLIER HOME HEALTH CARE	1		STREET ADDRESS, CITY, STATE, ZIP COD 1351 SILHAVY RD STE 200 VALPARAISO, IN 46383		0/01/2014	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 174	"Emergency Proced Anchor Home Health Orientation Manual or "Manipulation of the tracheostomy care or If the tracheostomy care or If the tracheostomy to replace the to provide the patient most appropriate act Replace the tracheostomy tube or 3. Occlude the storesuscitator bag and at a rate of 8 to 16 ti assistance can be streinsertion, observe possible have somethis color is bluish or significantly, stop try the stoma and ventil resuscitator bag and assistance can be of breathe on his own, within 30 seconds or possible. You may of trach tube whose sizt tube the patient uses easier than the stands wollen." B. The agency provide guidelines for other caregivers who dependent clients, to management of high setting, to promote size the stands of the possible of the provide guidelines for the caregivers who dependent clients, to management of high setting, to promote size the stands of the provide guidelines for the provide	reference document titled ures" from page 35 from the of Care Respiratory with no date stated, tube during suctioning or an lead to tube displacement by tube accidentally falls out, are tube immediately. In order of the with a patent airway, the strong should be taken: 1. In stomy tube, using the sterile or 2. Reinsert the original tube of an and use the manual of mask to ventilate the patient of the patient's color and if of the patient's color and if of the pulse rate changes ing to insert the tube, occlude attentiate with the manual of the manual of the patient of the patient can not an	G 1	74			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		157163	B. WING _			C 10/01/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SILHAVY RD STE 200 VALPARAISO, IN 46383		10/01/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 174	C. The agency pracheostomy Tube change the client's treat to Registered Nurses hands 2. DON clectient per Tracheostomy ties; he dominant hand. 6. Feragrange new tracheostomy ties; he dominant hand. 6. Feragrange new tracheostomy ties; he dominant hand. 6. Feragrange new tracheostomy ties; he dominant hand. 7. Gently rem tube and insert lubric obturator into stomalinward. 8. Following insert inner cannulated client is on a ventilate seconds. 9. Secure ties and dressing perprocedure 12. Che D. The agency procedure 12. Che D. The agency procedure accomprehe securing the tube, in patency by suctioning communication to the securing the tube, in patency by suctioning the tube, in patency by suctio	ontact with physician." procedure titled "Changing a with no date stated, "To acheostomy tube applies a Procedure 1. Wash an gloves. 3. Suction the pmy suctioning procedure. 4. pstomy tube 5. Cut existing pold tube in place with non - Pick up new tube in dominant move existing tracheostomy eated outer cannula with Insert downward and ginsertion, remove obturator, and 'lock' it into place. If the por, reconnect within 30 the tube in place with clean are Tracheostomy Care each cuff seal for leakage." Procedure titled "with no date stated, "This ensive plan that includes flating the cuff, maintaining ging and ensuring maintain airway patency." The titled "Mechanical late stated, "To prevent"	G 1	74		

AND DUAN OF CODDECTION		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		157163	B. WING			C 10/01/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SILHAVY RD STE 200 VALPARAISO, IN 46383	I	10/01/2014	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
G 174	Continued From pag	ge 34	G 17	4			
	a date of 8/4/00 stat adhere to and be in rules, and regulation other regulatory bod the home care indus						
	of Care" with a date policy of Anchor Hor health care services general supervision based on a written F established and peri	policy titled "Physician's Plan of 9/17/12 stated, "It is the ne Health Care that home are furnished under the of a doctor of medicine Plan of Care that is odically reviewed by the appropriateness and					
	necessity of home c patient's condition. implemented only in	are services relative to the All clinical services are accordance with a plan of a physician's written orders."					
	Physician's Orders" "It is the policy to provide patient / clie	policy titled "Verification of with a date of 9/17/12 stated, obtain physician orders to nt treatment and services. 2. supplement the Physician's					
	Services" with a date care services are prophysician's plan of core staff RN will compongoing comprehen the OASIS data sets appropriate time point revise the nursing cafederal / state / local	policy titled "Nursing Care e of 9/1/06 stated, "Nursing by by by by by by by by by by by by by by b					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157163	B. WING				C 01/2014
	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE 11 SILHAVY RD STE 200 LPARAISO, IN 46383	1 10/	01/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 174	execute the medical r a licensed physician . nursing staff sent to c	tal health care regimen and regime under the direction of Anchor will assure that are for high tech patients/ in the specific care modality	G	174			
G 176	484.30(a) DUTIES OF NURSE The registered nurse progress notes, coord	prepares clinical and dinates services, informs the ersonnel of changes in the	G	176			10/15/14
	Based on clinical rec and procedure review failed to ensure the re communicated with the tracheostomy / ventilal coordinated care with						
	diagnosis of chronic revidence communicate agency staff and the performing outer track changes with patient 2. On 9/25/14 at 5:20 Registered Nurse, incompared to the revidence of the staff of the staf						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		157163	B. WING		C		
NAME OF PROVIDER OR SUPPLIER		137 103			TREET ADDRESS, CITY, STATE, ZIP CODE	10/01/2014	
					351 SILHAVY RD STE 200		
ANCHOR HOME HEALTH CARE				VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
G 176	Continued From page 36		G	176			
	Continued From page 36 3. On 10/1/14 at 11 AM, a physician's nurse and office manager indicated the physician had not been notified that the agency was performing outer trach tube changes including the outer trach tube change on 9/5/14 by Employee A. The physician was the physician for patient #1. 4. The agency policy titled "Coordination of Care" with a date of 3/1/04 stated, "It is the policy of Anchor to provide coordination of care for all patients The clinical coordinator, clinical supervisor, or designated primary RN acts as the case manager to coordinate services to implement the physician's plan of care through out the treatment plan." 5. The agency procedure titled "Management of Home Ventilators" with no date stated, "To provide guidelines for home health nurses and other caregivers who care for ventilator dependent clients, to promote safety in management of high tech care in the home setting, to promote self care in the home. Applies to Registered Nurses Care coordination activities including contact with physician."						